ing cannulation, despite the purse string attaching the aortic cannula.

In our opinion, central cannulation is safe in acute aortic dissection repair, regardless of the systematic need for an open distal anastomosis, and the race to find the best arterial perfusion site seems useless since the evidence is right before everybody's eyes.

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References

1. Reece TB, Tribble CG, Smith RL, Singh RL, Stiles BM, Peeler BB, et al. Central cannulation is safe in acute aortic dissection repair. *J Thorac Cardiovasc Surg*. 2007;133:428-34.
2. Lijoi A, Scarano F, Dottori V, Parodi E, Casali G, Bartolozzi F. Stanford type A aortic dissection. A new surgical approach. *Tex Heart Inst J*. 1998;25:65-7.
3. Minatoya K, Karck M, Szpakowski E, Harringer W, Haverich A. Ascending aortic cannulation for Stanford type A acute aortic dissection: another option. *J Thorac Cardiovasc Surg*. 2003;125:952-3.
4. Karck M, Khaladj N, Shresta M, Kallenbach K, Hagl C, Haverich A. Direct ascending aortic cannulation in acute aortic dissection type A. *Interact Cardiovasc Thorac Surg*. 2006;5(suppl.2):S236.
5. Farhat F, Durand M, Boussel L, Sanchez I, Villard J, Jegaden O. Should a reimplantation valve sparing procedure be done systematically in type A aortic dissection? *Eur J Cardiothorac Surg*. 2007;31:36-42.
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Reply to the Editor:

We appreciate the comments from Drs Farhat, Sassard, and Jegaden on our article describing our experience with direct cannulation of dissected ascending aorta. They add further evidence speaking to the safety of this technique in specific subpopulations of patients with this disease. Their group uses this technique widely but avoids using it in dissections with suspected rupture or hematoma. Their exclusion criteria were similar to our study. As they describe, we have also placed purse strings in the aorta to secure the cannula without incident. This combined experience speaks to the feasibility of the central cannulation in ascending aortic dissections, which remains a safe cannulation option in selected situations for surgeons dealing with this disease.

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A meta-analysis of minimally invasive coronary artery bypass versus percutaneous coronary intervention with stenting for isolated left anterior descending artery disease is indispensable

To the Editor:

We read with great interest a meta-analysis of randomized trials of off-pump coronary artery bypass versus percutaneous coronary intervention (PCI) by Bainbridge and associates.[1] In response to a meta-analysis by Boodhwani and colleagues[2] of randomized trials comparing surgical versus percutaneous treatment of isolated left anterior descending (LAD) artery disease, we[3] conducted a meta-analysis of then-available 5 trials of minimally invasive direct coronary artery bypass (MIDCAB) versus PCI with stenting in the form of a letter to the editor. In the meta-analysis by Boodhwani and coworkers,[2] significant heterogeneity existed because of the inclusion of both conventional coronary artery bypass and MIDCAB in the surgical group and both PCI with or without stenting in the percutaneous group. So far as the meta-analysis by Bainbridge and associates[1] is concerned, although 5 of 6 included trials used MIDCAB technique in the majority of patients in the surgical arm, in 1 trial by Eefting and colleagues[4] (the largest trial in the 6 trials) surgical access to the heart was achieved via median sternotomy in 67%. Although the trial by Eefting and coworkers[4] included patients with multivessel disease, the other 5 trials were exclusively of LAD stenting versus left internal thoracic artery–to–LAD anastomosis. Furthermore, a flaw of the systematic review by Bainbridge and associates[1] was missing a trial by Kim and colleagues[5] published in 2005 despite comprehensive searches up until May 2006. Therefore, we would like to advocate a meta-analysis of currently available 6 homogeneous randomized trials of MIDCAB versus PCI with stenting for isolated LAD disease, including the trial by Kim and coworkers[5] and 5 trials except for the trial by Eefting and associates[4] included in the meta-analysis by Bainbridge and colleagues.[1]

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References

1. Bainbridge D, Cheng D, Martin J, Novick R; Evidence-based Peri-operative Clinical Outcomes Research (EPiCOR) Group. Does off-pump or minimally invasive coronary artery bypass reduce mortality, morbidity, and resource utilization when compared with percutaneous coronary intervention? A meta-analysis of randomized trials. *J Thorac Cardiovasc Surg*. 2007;133:623-31.
2. Boodhwani M, Rubens FD, Sellke FW, Mesana TG, Ruel M. Mortality and myocardial infarction following surgical versus percutaneous revascularization of isolated left anterior descending artery disease: a meta-analysis. *Eur J Cardiothorac Surg*. 2006;29:65-70.
3. Takagi H, Kato T, Matsuno Y, Umemoto T. Minimally invasive direct coronary artery bypass versus stenting. *Eur J Cardiothorac Surg*. 2006;29:632.
4. Eefting F, Nathoe H, van Dijk D, Jansen E, Lahpor J, Stella P, et al. Randomized comparison between stenting and off-pump bypass surgery in patients referred for angioplasty. *Circulation*. 2003;108:2870-6.
5. Kim JW, Lim DS, Sun K, Shim WJ, Rho YM. Stenting or MIDCAB using ministernotomy for revascularization of proximal left anterior descending artery? *Int J Cardiol*. 2005;99:437-41.
doi:10.1016/j.jtcvs.2007.03.047

Reply to the Editor:

Takagi and colleagues are correct in suggesting that the trial by Kim and associates[1] is relevant to our meta-analysis of randomized trials of off-pump coronary artery bypass/minimally invasive direct coronary artery bypass (OPCAB/MIDCAB) versus percutaneous coronary intervention (PCI).[2] We remain uncertain why this randomized trial was not identified despite multiple independent searches performed by experts. It may be that the trial was not